MISSING LINKS IN ACHIEVING EFFECTIVE SERVICES*

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IT is finally becoming acknowledged and accepted that America's health-delivery system is in a state demanding immediate renovation. Fragmentation and disorganization of the medical system have led to inefficiency, duplication of effort, and wasted money, services, and time. Those who suffer most are the consumers. They are being denied a basic right—good health—because the health-care delivery system remains incapable of providing and insuring that right. In my opinion the problem of health care will be relieved when the consumer assumes a new position in which he directly influences health-care policy at every level in order to produce changes in the system. In addition, a second precursor of effective medical-care delivery is public financing.

England and Wales of the United Kingdom and Sweden offer ready proof that a public-health policy can provide a successful method of insuring good health within a country. Contrary to popular belief, the United States does not provide the world's most effective health care. Osler Peterson et al. introduced evidence to the contrary in 1967 in an article published in the *Lancet* entitled What is Value for Money in Medical Care. Peterson and his associates compared health statistics and policies in England and Wales, Sweden, and the United States, and noted that all are healthy and affluent industrial countries. Despite that similarity their development of health services has led to striking differences in the provision and utilization of medical care. Where the United States relies on free enterprise to provide health care, the two European countries observed in the study have national-health policies. In the

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United States the percentage of the gross national product (GNP) invested in health expenditures, as observed and reported by those men, has been increasing steadily, while in England and Wales relative expenses supported by the national health mechanism have been stable. Health expenses in all of these countries are reasonably similar, although the percentage of the GNP distributed in 1963 to allay health needs in the United States is somewhat higher than in England, Wales, and Sweden. There are, however, more significant distinctions between the United States and those nations with national health policies. Statistics reveal that the United States has 136.9 physicians for every 100,000 Americans; Sweden has 105.5 physicians per 100,000 people; and the United Kingdom occupies a position between the two. Average annual doctor-patient contact is notably higher in the United States than in either Sweden or the United Kingdom. It must be noted, however, that the reporting of such statistics is probably less widespread and accurate in the United States.

It is my contention that the United States has the lowest standards for health care of all three countries. For example, maternal-mortality rates from 1963 to 1965 placed the United States in the 12th position in a list of 20 industrial western nations, whereas Sweden placed first with the lowest maternal-death rate. In a 1965 survey of male life expectancy at birth, the United States ranked 18th with the lowest expectancy rate, while the United Kingdom ranked 10th and Sweden boasted the highest life-expectancy rate. In 1967 the United States placed 14th with the highest infant mortality rate while the United Kingdom again placed 10th and Sweden first.

It is true that the technical problems involved in statistical comparisons of different nations present problems in both continuity and accuracy. However, Peterson's study certainly indicates a significant difference in the health-delivery systems of those countries that invest the same percentage of their GNP in health care.

The factors that account for the differences in quality and effectiveness of health-care delivery in the United Kingdom, Sweden, and the United States must relate to the major distinctions in the over-all health systems of these countries. Financing is an integral component of health delivery, and I want to emphasize here that the governments of England, Wales, and Sweden finance a national-health policy whereas the United States lacks such a program. An indirect relation between the

quality of health care received and the cost of care delivered is strongly indicated. Perhaps the relative failure of the United States originates in the lack of genuine incentive for improvement which characterizes much of its medical profession. Because health care is bound by few restraints, the quality of care delivered is determined almost exclusively by the competency, motivation, and concern of the individual health-care deliverer.

It is an oversimplified and shortsighted viewpoint which holds that the inability of individual consumers to meet the cost of medical care is the primary factor that obstructs effective health delivery. There are other methods and concerns which should not be ignored. For instance, there have been many legislative attempts at generating national health-insurance mechanisms. They have been concerned almost exclusively with payment. The American Medical Association Medi-Credit System is a foremost example. But in the first year of Medicaid and Medicare, the rate of increase in physicians' fees tripled, and the rate of increase in hospital fees multiplied five times. It seems obvious that the increase was the result of the unrestricted and unplanned allocation of money to a medical-care system without attempting to make the necessary basic changes in its organizational, delivery, and manpower components.

One major change for improving health delivery could be the replacement of the solo practitioner by group practice. In comparison with the knowledge, skill, and technical resources available from a team of physicians, the solo practitioner is considerably less effective. Physicians who work together in an organized fashion can share their knowledge and technical skills to improve the health care delivered to their patients. The merger would be advantageous to physicians as well as consumers because financial benefits would result from the savings accumulated through shared expenses and overhead.

An in-depth analysis of the present state and the future needs of our health system is a prerequisite to the development of a national health insurance policy. One important consideration is human nature, which might serve as an ally in this effort since we can provide financial rewards as incentives for change. An appeal to the average American's desire for money and its material benefits is perhaps the most effective way of inducing significant change in a relatively short period of time within a system as complex as health delivery.

Group practice could encourage the spread of family-oriented care. By focusing on the health-related resources and problems of the family group, we would be able to treat the social and psychological elements of disease as well as its basic biological components. Dealing with the family unit could hasten achievement of the ultimate goal of medicine, prevention of disease, by advancing early and thorough diagnosis.

A third modification demanded of the health system is comprehensive care, which must be a primary component of a national health-insurance program. Groups of doctors that service families would decrease the present fragmentation of effort and reduce expenses for physicians and consumers. Comprehensive care means that the individual components of medical care are interrelated to provide coordination, economy, and efficiency.

Often unconsidered in national-health financing is the relation of the community to individual and family medical problems. Intimate participation of community members should exist at all economic and social levels. Community people belong on the hospital boards and in neighborhood councils to influence health-care policy to meet community needs. The major policy decisions to determine the focus of a care program intended to meet the needs of a specific community can, and should, only be made with the full participation of the community to be served. Only in this manner can services be tailored to meet the special needs of that community.

A community-oriented national-health program that offers family-care delivery by teams of physicians could do much to alleviate fragmentation and costly disorganization. In its efforts to design an efficient health-insurance policy, the Technical Committee of the Committee for National Health Insurance stresses comprehensive care and service. Its program states: "The administrative arrangements and the finances of the National Health Insurance program should be designed to encourage the organization of professional, technical, and supporting personnel and health teams and groups capable of providing comprehensive per capita payments as an alternative to the prevailing fee-for-service method of payment!"

The late Dr. Richard Weinerman explained in a position paper the way the goals of rational and comprehensive delivery of medical care could be achieved. Progress toward a rational health-delivery system is inhibited rather than advanced when changes are imposed by rigid legis-

lation and strict administrative procedures. Instead, advancement can result only through the initiative of motivated consumers and deliverers of health care. Dr. Weinerman explains: "This requires a program for planned progress through the stated goals. It demands also a pervasive flexibility which can allow the changed social and scientific determinants of health and medical care to lead to modification of program goals as well as the means."

Government financing should be aimed at increasing efficiency and economy within the medical system. Dr. Weinerman presents several means of achieving that objective:

1. The avoidence of duplication and waste through coordinated services;

2. The reduction of high costs of professional service through the encouragement of group or team practice and the expanded use of supportive personnel;

3. The elimination of unnecessary costs of hospitalization through improved availability of less expensive ambulatory and long-term institutional and home care services;

4. Reduction of high costs of specialty services, major surgery and expensive laboratory and x-ray procedures, appliances and devices, and use of drugs through achievement of economies and the utilization of available resources;

5. Avoidance of uncontrolled fee-for-service and cost-reimbursement methods of payment to providers of service;

6. Improved efficiency and lower operational unit cost through continuous educational and in-service training opportunities for providers, consumers, and policy makers in the national program;

7. Elimination of the costly process of making initial eligibility determinations and querying status before the payment of bills.

To stimulate physicians' cooperation in achieving the goals outlined by Dr. Weinerman, financial incentives should be introduced to encourage doctors to adopt capitation-payment arrangements under group auspicies. Doctors should be convinced that accepting and promoting this change will produce additional savings through increased efficiency, payment of bonuses, or other financial support. Health personnel that functions as a team, delivers comprehensive family care, and uses allied health personnel would be rewarded because their efficiency would improve, thus increasing their financial realization. Direct rewards could

also be provided for establishing liaisons with back-up hospitals, specialty resources, and facilities for long-term care.

The next phase toward financial savings lies in planning and coordinating regional primary-care units and eliminating duplicate facilities, costly services, and supplies. Finally, incentives must be directed toward cost reimbursement to physicians, control over potential health risks, early detection of disease, and techniques of family-health maintenance, in relation to local social-welfare and associated community services.

Because the amount of money expended for the delivery of health care in past years has steadily increased, and since traditional measuring devices indicate little or no improvement, it is obvious that changes are essential. Perhaps we have been measuring the wrong symptoms or conditions and are directed toward goals which are no longer desirable. Instead of relying on traditional goals, we must begin to direct our resources toward earlier diagnosis and, finally, toward prevention of disease. The effectiveness of these methods will be measured by the improvement of the quality of life for those afflicted by chronic and degenerative diseases.

Today we are presented with a unique opportunity to improve America's health-delivery system. Health is and will remain a politically safe issue at a time when the country is polarized in many other areas. Now is the time for direct action to achieve the realistic dream of a universally effective health-delivery system in the United States.